		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0015651

Facility Name: Bethany Terrace Nursing Centre

Address: 8425 North Waukegan (Number) Morton Grove (City) 60053 (Zip Code)

County: Cook

Telephone Number: (847) 965-8100 **Fax #** ( )

IDPA ID Number: 36-2012788

Date of Initial License for Current Owners: 2/13/69

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Harold Reisler **Telephone Number:** (773) 989-1465

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/03 to 9/30/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Wolfgang Mayer
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/03 Ending: 9/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	103	Skilled (SNF)	103	37,698	1
2		Skilled Pediatric (SNF/PED)			2
3	170	Intermediate (ICF)	170	62,220	3
4		Intermediate/DD			4
5	2	Sheltered Care (SC)	2	732	5
6		ICF/DD 16 or Less			6
7	275	TOTALS	275	100,650	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,396	2,060	6,219	9,675	8
9	SNF/PED					9
10	ICF	32,502	32,092	4,158	68,752	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,898	34,152	10,377	78,427	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.92%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 2/13/65

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified _____ and days of care provided 4,695

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 10/1/03 Fiscal Year: 9/30/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/03 Ending: 9/30/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	551,798	49,479	(58,934)	542,343		542,343	(45,078)	497,265			1
2	Food Purchase		547,550		547,550		547,550		547,550			2
3	Housekeeping	338,256	64,280	6,244	408,780		408,780		408,780			3
4	Laundry	104,746	69,881	10,534	185,161		185,161		185,161			4
5	Heat and Other Utilities			273,518	273,518		273,518		273,518			5
6	Maintenance	104,519	21,060	112,385	237,964		237,964		237,964			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,099,319	752,250	343,747	2,195,316		2,195,316	(45,078)	2,150,238			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	4,766,673	484,549	102,106	5,353,328		5,353,328		5,353,328			10
10a	Therapy	80,950	1,338	352,807	435,095		435,095		435,095			10a
11	Activities	131,511	3,779	25,813	161,103		161,103		161,103			11
12	Social Services	94,884		1,179	96,063		96,063		96,063			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Mission Spiritual	61,167	2,631	1,588	65,386		65,386		65,386			15
16	**TOTAL Health Care and Programs**	5,135,185	492,297	483,493	6,110,975		6,110,975		6,110,975			16
	C. General Administration											
17	Administrative	109,477		248,444	357,921		357,921	(313,324)	44,597			17
18	Directors Fees											18
19	Professional Services			41,117	41,117		41,117		41,117			19
20	Dues, Fees, Subscriptions & Promotions			33,030	33,030		33,030		33,030			20
21	Clerical & General Office Expenses	258,239	51,447	525,494	835,180		835,180	(264,687)	570,493			21
22	Employee Benefits & Payroll Taxes			751,862	751,862	10,178	762,040		762,040			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,341	12,341		12,341		12,341			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			188,975	188,975	(10,178)	178,797		178,797			26
27	Other (specify):*		820	1,526	2,346		2,346		2,346			27
28	**TOTAL General Administration**	367,716	52,267	1,802,789	2,222,772		2,222,772	(578,011)	1,644,761			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,602,220	1,296,814	2,630,029	10,529,063		10,529,063	(623,089)	9,905,974			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Bethany Terrace Nursing Centre #0015651 Report Period Beginning: 10/1/03 Ending: 9/30/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			684,119	684,119		684,119	30,836	714,955			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			37,212	37,212		37,212		37,212			35
36	Other (specify):*											36
37	**TOTAL Ownership**			721,331	721,331		721,331	30,836	752,167			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			2,093	2,093		2,093		2,093			41
42	Provider Participation Fee			149,878	149,878		149,878		149,878			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			151,971	151,971		151,971		151,971			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,602,220	1,296,814	3,503,331	11,402,365		11,402,365	(592,253)	10,810,112			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/03 Ending: 9/30/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(45,078)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	30,836	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(264,687)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Misc Income	(1,649)	17		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (280,578)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(201,859)	17	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (201,859)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (482,437)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Bethany Terrace Nursing Centre

ID# 0015651

Report Period Beginning: 10/1/03

Ending: 9/30/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Public Relations	$ (109,816)	17	1
2	Special Revenue	(1,524)	17	2
3	Health Info Mgt	(125)	17	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(111,465)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 **Report Period Beginning:** 10/1/03 **Ending:** 9/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(45,078)	0	0	0	0	0	0	0	0	0	0	(45,078)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(45,078)	0	0	0	0	0	0	0	0	0	0	(45,078)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(313,324)	0	0	0	0	0	0	0	0	0	0	(313,324)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(264,687)	0	0	0	0	0	0	0	0	0	0	(264,687)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(578,011)	0	0	0	0	0	0	0	0	0	0	(578,011)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(623,089)	0	0	0	0	0	0	0	0	0	0	(623,089)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 **Report Period Beginning:** 10/1/03 **Ending:** 9/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	30,836	0	0	0	0	0	0	0	0	0	0	30,836	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	30,836	0	0	0	0	0	0	0	0	0	0	30,836	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(592,253)	0	0	0	0	0	0	0	0	0	0	(592,253)	45

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/03 Ending: 9/30/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Methodist Hospital	Chicago, IL	Hospital

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		Corporate Salary	$ 92,715	Methodist Hospital of Chicago	100.00%	$ 50,993	$ (41,722)	1
2	V		Corporate Benefits	129,437	Methodist Hospital of Chicago	100.00%	54,364	(75,073)	2
3	V		Corporate Pro Fees	77,751	Methodist Hospital of Chicago	100.00%	42,763	(34,988)	3
4	V		Corporate Other	47,280	Methodist Hospital of Chicago	100.00%	26,004	(21,276)	4
5	V		Hospital Administrative	28,800	Methodist Hospital of Chicago	100.00%		(28,800)	5
6	V		Hospital Accounting	100,949	Methodist Hospital of Chicago	100.00%	100,949		6
7	V		Hospital Purchasing	47,824	Methodist Hospital of Chicago	100.00%	47,824		7
8	V		Hospital EDP	39,821	Methodist Hospital of Chicago	100.00%	39,821		8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 564,577			$ 362,718	$ * (201,859)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/03 Ending: 9/30/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/03 Ending: 9/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Methodist Hospital of Chicago
Street Address: 5025 N Paulina
City / State / Zip Code: Chicago, IL 60640
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		Corporate Salary	% to Total Cost	100	Various	$ 370,858	$	25	$ 92,715	1
2		Corporate Benefits	% to Total Cost	100	Various	517,748		25	129,437	2
3		Corporate Pro Fees	% to Total Cost	100	Various	311,003		25	77,751	3
4		Corporate Other	% to Total Cost	100	Various	189,120		25	47,280	4
5		Hospital Administration	% to Total Cost	100	Various	28,800		100	28,800	5
6		Hospital Accounting	% to Total Cost	100	Various	403,796		25	100,949	6
7		Hospital Purchasing	% to Total Cost	100	Various	207,932		23	47,824	7
8		Hospital Data Processing	% to Total Cost	100	Various	442,456		9	39,821	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,471,713	$		$ 564,577	25

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/03 Ending: 9/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 **Report Period Beginning:** 10/1/03 **Ending:** 9/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1999	8
	2000	9
	2001	10
	2002	11
	2003	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bethany Terrace Nursing Centre COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0015651

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/03 Ending: 9/30/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,175 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	183,600	1965	$ 189,809	1
2	Terrace Land Triangle		1996	92,064	2
3	TOTALS	183,600		$ 281,873	3

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/03 Ending: 9/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	275		1965	1965	$ 1,332,134	$ 2,467	40	$ 33,303	$ 30,836	$ 1,330,429	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Remodel Terrace Suites & Triangle			2004	1,473,358	24,556	20	24,556		24,556	9
10	Display Case			2004	569	22	15	22		22	10
11	Display Case			2004	902	35	15	35		35	11
12	Plumbing for Remodeling Suites			2004	132,292	2,205	20	2,205		2,205	12
13	RSTU Cards			2004	5,127	128	10	128		128	13
14	Exhaust Fan Relays			2004	1,902	63	10	63		63	14
15	Exhaust for Soiled Linen			2004	1,023	34	10	34		34	15
16	Exhaust Fan Relays			2004	3,092	103	10	103		103	16
17	Coil and Compressor for Cooler			2004	5,135	171	10	171		171	17
18	Exhaust Fan Relay Wiring/Circuiting			2004	3,836	48	20	48		48	18
19	Roof Phase 3 Terrace			2003	275,652	27,565	10	27,565		29,862	19
20	Laundry Room Remodeling			2003	49,450	2,473	20	2,473		3,297	20
21	Parker Bathtub			2003	7,818	782	10	782		1,173	21
22	Doors in Friendship & Asbury Wings			2003	2,782	185	15	185		247	22
23	Phone and Data Lines Homeir Lane			2003	1,508	151	10	151		189	23
24	Electrical Pipe on Roof			2003	9,481	474	20	474		672	24
25	Electricl Pipe on Roof			2003	4,330	217	20	217		289	25
26	Cast Iron Waste In Boiler Room			2003	1,560	156	10	156		208	26
27	Signage "Called to Care"			2003	1,409	141	10	141		188	27
28	Panic Device Fire Rated			2003	647	65	10	65		81	28
29	Panic Device Fire Rated			2003	647	65	10	65		81	29
30	Panic Device Fire Rated			2003	647	65	10	65		81	30
31	Panic Device Fire Rated			2003	647	65	10	65		81	31
32	Panic Device Fire Rated			2003	647	65	10	65		81	32
33	Expansion Tanks			2003	4,405	441	10	441		551	33
34	Fire Rated Panic Device			2003	663	66	10	66		77	34
35	Chiller			2002	39,169	2,611	15	2,611		6,745	35
36	Roof Replacement			2002	540,218	54,022	10	54,022		112,546	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/03 Ending: 9/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Bolier Tubes	2002	$ 11,926	$ 596	20	$ 596	$	$ 1,639	37
38	Remote Alarm Stations Friendship	2002	3,038	304	10	304		811	38
39	Magnetic Door Holders	2002	3,850	385	10	385		1,027	39
40	Windows (309) Thermopane Weather Tite	2001	201,057	5,026	40	5,026		16,753	40
41	Remodel Bendix & Anderson Lanes	2001	455,626	22,781	20	22,781		75,937	41
42	Carpet Lobby	2001	3,606	721	5	721		2,163	42
43	Garbage Disposal	2001	2,483	496	5	496		1,614	43
44	Elkay Handicapp Drinking Fountain	2001	1,580	158	10	158		579	44
45	Nurse Call Sys Bendix & Anderson	2001	62,523	6,252	10	6,252		22,924	45
46	Bearing Assemb. for Circ. Pump	2001	1,397	140	10	140		513	46
47	Voice Calling For Bendix Unit	2001	6,143	614	10	614		2,200	47
48	Light Pole in Parking Lot	2001	2,840	284	10	284		1,018	48
49	Valve for Sprinkler System	2001	635	42	15	42		147	49
50	Boiler Retubing	2001	3,541	354	10	354		1,003	50
51	Phone Cabling Anderson Lane	2001	7,180	718	10	718		2,633	51
52	2000 Land Improvements	2000	29,465	2,753	Various	2,753		12,388	52
53	2000 Buildings	2000	286,619	7,269	Various	7,269		32,711	53
54	2000 Fixed Equipment	2000	36,225	3,917	Various	3,917		17,631	54
55	1999 Land Improvements	1999	23,641	1,406	Various	1,406		7,736	55
56	1999 Buildings	1999	155,550	7,939	Various	7,939		43,665	56
57	1999 Fixed Equipment	1999	225,368	12,624	Various	12,624		70,214	57
58	1998 Buildings	1998	184,894	9,452	Various	9,452		61,442	58
59	1998 Fixed Equipment	1998	6,728	467	Various	467		3,050	59
60	1997 Buildings	1997	1,378,645	34,793	Various	34,793		260,948	60
61	1997 Fixed Equipment	1997	9,680	884	Various	884		6,634	61
62	1996 Buildings	1996	1,372,036	91,908	Various	91,908		781,217	62
63	1996 Fixed Equipment	1996	34,794	2,585	Various	2,585		27,095	63
64	1995 Land Improvements	1995	9,325	933	Various	933		8,859	64
65	1995 Buildings	1995	2,067	206	Various	206		1,964	65
66	1995 Fixed Equipment	1995	77,386	5,553	Various	5,553		52,752	66
67	1994 Land Improvements	1994	1,460	122	Various	122		1,278	67
68	1994 Buildings	1994	153,823	7,692	Various	7,692		153,823	68
69	1994 Fixed Equipment	1994	118,542	5,980	Various	5,980		109,272	69
70	TOTAL (lines 4 thru 69)		$ 8,774,723	$ 354,795		$ 385,631	$ 30,836	$ 3,297,883	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/03 Ending: 9/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 8,774,723	$ 354,795		$ 385,631	$ 30,836	$ 3,297,883	1
2	1993 Buildings	1993	221,691	18,477	Various	18,477		212,454	2
3	1993 Fixed Equipment	1993	3,200	186	Various	186		2,147	3
4	1992 Buildings	1992	1,276,036	98,132	Various	98,132		1,226,643	4
5	1992 Fixed Equipment	1992	290	19	Various	19		241	5
6	1991 Fixed Equipment	1991	1,112	74	Various	74		1,000	6
7	1990 Buildings	1990	2,272	151	Various	151		2,196	7
8	1989 Buildings	1989	305,445	19,088	Various	19,088		295,898	8
9	1988 Land Improvements	1988	92,988	3,719	Various	3,719		61,372	9
10	1988 Buildings	1988	198,890	11,699	Various	11,699		193,040	10
11	1987 Buildings	1987	56,094	3,119	Various	3,119		54,537	11
12	1986 Buildings	1986	524,980	27,638	Various	27,638		511,167	12
13	1985 Buildings	1985	451,631	22,108	Various	22,108		440,577	13
14	1984 Buildings	1984	81,860	2,047	Various	2,047		81,860	14
15	1975 Buildings	1975	60,024	2,002	Various	2,002		59,024	15
16	1973 Buildings	1973	68,384	2,136	Various	2,136		61,793	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,119,620	$ 565,390		$ 596,226	$ 30,836	$ 6,501,832	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/03 Ending: 9/30/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,784,931	$ 95,097	$ 95,097	$	various	$ 1,331,270	71
72	Current Year Purchases	283,953	18,524	18,524		various	18,524	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,068,884	$ 113,621	$ 113,621	$		$ 1,349,794	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Activities	1999 Ford Eldorado Bus	2004	$ 19,125	$ 3,825	$ 3,825	$	5	$ 3,825	76
77	Maintenance	1988 Ford Van	1988	35,783				4	35,783	77
78	Facility Maintenance	1988 Ford Wagon	1988	16,826				4	16,826	78
79	Yard Maintenance	International Trailor	1970	3,000				4	3,000	79
80	TOTALS			$ 74,734	$ 3,825	$ 3,825	$		$ 59,434	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 14,545,111	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 682,836	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 713,672	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 30,836	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,911,060	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 37,212 Description: Mattress Rentals
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/03 Ending: 9/30/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$	3,619	$ 197,431	$	3,619	$ 197,431	1
2	Licensed Speech and Language Development Therapist		hrs		1,395	82,201		1,395	82,201	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		2,539	135,519		2,539	135,519	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	7,553	$ 415,151	$	7,553	$ 415,151	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Bethany Terrace Nursing Centre **#** 0015651 **Report Period Beginning:** 10/1/03 **Ending:** 9/30/04

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 9/30/04 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 2,794,024	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		9,907,567	3
4	Supply Inventory (priced at)		451,067	4
5	Short-Term Investments		12,822,538	5
6	Prepaid Insurance		1,024,015	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due to Third Party		(2,831,062)	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$ 24,168,149	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		74,498	12
13	Land		6,106,028	13
14	Buildings, at Historical Cost		80,269,824	14
15	Leasehold Improvements, at Historical Cost		2,361,169	15
16	Equipment, at Historical Cost		15,565,755	16
17	Accumulated Depreciation (book methods)		(51,682,561)	17
18	Deferred Charges		1,011,040	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		10,629,165	21
22	Other Long-Term Assets (spe Construction in Progress		1,311,294	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 65,646,212	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$ 89,814,361	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 1,716,725	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		767,216	29
30	Accrued Salaries Payable		3,876,550	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		137,497	33
34	Deferred Compensation		36,250	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Third Party Payors		1,507,338	36
37	Other Current Liabilities		826,644	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$ 8,868,220	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		44,360,884	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Est. Liab. For Malpractice Losses		1,388,275	43
44	Accrued Pension Cost		957,490	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 46,706,649	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$ 55,574,869	46
47	**TOTAL EQUITY(page 18, line 24)**	$	$ 34,239,492	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$	$ 89,814,361	48

***(See instructions.)**

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/03 Ending: 9/30/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 40,737,383	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 40,737,383	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	918,484	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Gain/Loss for Period**	(5,534,880)	15
16	Other (describe) **Corporate Income**	(1,881,495)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (6,497,891)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 34,239,492	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/03 Ending: 9/30/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 16,095,245	1
2	Discounts and Allowances for all Levels	(4,113,551)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,981,694	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	3,695	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	45,078	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,649	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 50,422	23
	D. Non-Operating Revenue		
24	Contributions	264,687	24
25	Interest and Other Investment Income***	24,046	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 288,733	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,320,849	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,195,316	31
32	Health Care	6,110,975	32
33	General Administration	2,222,772	33
	B. Capital Expense		
34	Ownership	721,331	34
	C. Ancillary Expense		
35	Special Cost Centers	2,093	35
36	Provider Participation Fee	149,878	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,402,365	40
41	**Income before Income Taxes (line 30 minus line 40)****	918,484	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 918,484	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/03 Ending: 9/30/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 77,916	$ 37.46	1
2	Assistant Director of Nursing	2,720	2,720	95,602	35.15	2
3	Registered Nurses	65,256	65,256	1,105,293	16.94	3
4	Licensed Practical Nurses	37,607	37,607	650,368	17.29	4
5	Nurse Aides & Orderlies	253,155	253,155	2,376,721	9.39	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,101	2,101	54,065	25.73	7
8	Rehab/Therapy Aides	5,985	5,985	102,018	17.05	8
9	Activity Director	4,152	4,152	61,199	14.74	9
10	Activity Assistants	24,268	24,268	249,481	10.28	10
11	Social Service Workers					11
12	Dietician	1,769	1,769	22,399	12.66	12
13	Food Service Supervisor	5,377	5,377	64,670	12.03	13
14	Head Cook	43,598	43,598	394,649	9.05	14
15	Cook Helpers/Assistants	8,400	8,400	67,148	7.99	15
16	Dishwashers					16
17	Maintenance Workers	6,755	6,755	106,388	15.75	17
18	Housekeepers	41,102	41,102	331,334	8.06	18
19	Laundry	12,256	12,256	102,858	8.39	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	34,764	34,764	699,893	20.13	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	551,345	551,345	$ 6,562,002 *	$ 11.90	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/03 Ending: 9/30/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kenneth Kolich	Administrator		$ 109,477
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 109,477

B. Administrative - Other

Description	Amount
Corporate Allocation	$ 248,444
TOTAL (agree to Schedule V, line 17, col. 3)	$ 248,444
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Cassiday, Schade, & Gloor	Legal Fees	$ 26,840
Sonnenscein Nath & Rosenthal	Legal Fees	3,925
Quality Care Consulting Svcs	Consulting	1,971
Carol Gordon	Social Services Consulting	2,295
Carlin & Associates	Health Info Consulting	6,020
AdminaStar Federal	Patient Accounts	66
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 41,117

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 24,816
Unemployment Compensation Insurance	11,707
FICA Taxes	482,219
Employee Health Insurance	224,423
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Group Life Insurance	8,698
TOTAL (agree to Schedule V, line 22, col.8)	$ 751,863

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	21,337
Health Care Worker Background Check	693
(Indicate # of checks performed)	
Dues & Subscriptions	10,858
Other	143
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 33,031

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	10,203
Seminar Expense	2,138
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,341

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 Report Period Beginning: 10/1/03 Ending: 9/30/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Bethany Terrace Nursing Centre # 0015651 **Report Period Beginning:** 10/1/03 **Ending:** 9/30/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network - $9,426**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,936** Line **10.02**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **149,878**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **29,414**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation. N/A
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **PricewaterhouseCoopers LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Not Available yet**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.